Community-Connected Residential Services
Workgroup Deliberations and Guidance

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DSS' System of Care Procurement

The Department of Social Services began its efforts to reform its purchased services system in September 2002 with the convening of a Procurement Review Workgroup. That group made a series of recommendations for designing, managing, and purchasing an integrated service system. A report describing its deliberations and recommendations was posted (and is still available) on the DSS website in May 2003, with an invitation to partners and colleagues to offer their feedback and comments. The Report has guided the Department's plans to redesign and reprocure current categorical services of $160M in Commonworks, residential treatment and group homes; $50M in contracted foster care; and $25M in family based services. Following the conclusion of the Workgroup, the Department launched three concurrent planning efforts.

- The Community-Connected Residential Services Workgroup was charged with identifying clinical, managerial, and network practices required to support a more thorough connection of residential services to community systems, providing readiness guidance to the provider community, and informing the state agencies' efforts to support new approaches to residential programming.
- A Case Management Roles & Responsibilities Consensus-building Process will define DSS' and the lead agencies' case management decision-making roles and responsibilities within the public / private partnership. The Procurement Review Workgroup identified the need to clearly articulate the extent to which DSS would authorize lead agencies to make certain case-related decisions. In its recommendation that DSS hold lead agencies accountable for outcomes, the group stated that accountability, responsibility, and authority must be commensurate.
- The Departmental Procurement Planning Process began with extensive "debriefing sessions" with in-house experts to shape the content of the system of care and will utilize regional teams to craft the operational design for the system of care procurement. This effort is, of course, multi-faceted and spans the Department's work with families, program design, operational and financing design, and work with key partners.

In addition to these DSS efforts, Department staff participate in many Executive Office of Health and Human Services' projects, including its Purchasing Strategies Initiative and its children's policy and planning work teams. The overarching goal of EOHHS and the Children, Youth, & Families Cluster is to create a comprehensive children's system of care. That EOHHS and DSS are using system of care terminology reflects a shared philosophy, commitment, and strategic direction. However, it is also often the source of confusion. The Department's system of care procurement got its name from the Procurement Review Workgroup's recommendation that DSS use the system of care philosophy and framework to guide the redesign and reprocurement of its service system. The benefit of doing so is twofold: it improves the DSS service system and it positions the DSS system to better connect with the larger EOHHS-wide children's service system.

DSS is in the early stages of the planning process so there are many questions still to be answered, but there are some certainties:

- One of the ultimate measures of DSS' success is increasing the number of children who enter adulthood with a healthy sustained relationship with a caring adult. Such a relationship could occur in a biological family, adoptive family, guardian, or a responsible caring adult with whom an older youth has a meaningful connection. Accomplishing this requires focusing on increasing community tenure and decreasing the time a youth spends in out-of-community placements.

- As much of the service system and its management should be as close to communities and DSS Area Offices as possible. The implementation and achievement of this will require a multi-year transition as Area Offices and their lead agency partners and service networks develop capacity to include an increasingly greater range of service models and dollars. The Regional Resource Centers will play a role in supporting this evolution. The starting point and process of development will likely vary across the state.

- EOHHS has made a secretariat-wide commitment to reduce the reliance on residential / institutional placements and increase the capacity to support children and families in community settings. Accomplishing this requires innovation and reform across the service system, supported by fundamental changes in financing, purchasing, and information sharing structures and processes.

The DSS system of care procurement is the natural evolution of the Department's service system and our practice with families. Several past and current programs offer important lessons for building an integrated service system. The first Commonworks Program (fondly called Commonworks 1) built networks of residential providers, each with their own maximum obligation contract, and provided valuable lessons about the nature and functioning of healthy horizontal networks. The second Commonworks Program (which exists today) introduced lead agencies paid through a case rate system with network providers subcontracted by the lead agency, providing lessons about the application of managed care approaches to child welfare. The Family Based Services Program (FBS) brought the provider network concept to family and community services and established a statewide concerted effort to involve families in service planning teams. Multi-Disciplinary Assessment Teams (MDATs) and the Collaborative Assessment Program (CAP) had provided smaller scale experience with family involvement upon which to build. Family Group Conferencing (FGC) has since been introduced to the Department's casework practice. Community Connections coalitions have empowered communities to play a leadership and planning role in caring for children and have enhanced the work of FBS networks by bridging connections between traditional purchased services and informal supports. With recent changes in DSS' appropriation account structure and authority, we have the opportunity to adapt and apply these lessons throughout the service system as we breakdown program and funding silos.

Purpose of the Community-Connected Residential Services Workgroup

The purpose of the Community-Connected Residential Services Workgroup was to examine with providers the opportunities and challenges associated with one of the central areas of change in the service system. That area is connecting residential programs to community based services and supports, with the ultimate goal of increasing the community tenure of children who need some period of time in a residential treatment setting. The workgroup functioned as an advisory committee to the Department in order to identify the challenges that the provider community would face as we move forward with the new system of care and to craft and test ideas and guidance for meeting those challenges. Members represented residential, therapeutic foster care, and family based services provider agency executive, clinical, and financial directors from across the state. They shared both their enthusiasm and concerns about these changes and have provided valuable advice to their colleagues and to DSS.

The Workgroup members committed as a group to not dichotomize residential providers and community-based providers. Their collective commitment to community-based care is not intended to suggest that a particular type of provider is valued over another or is more capable. All providers and their programs have strengths that are important in DSS' system of care. The group also agreed that it could not / should not determine which provider type might be in the better position to be an Area-based Lead Agency. The provider type best positioned to connect residential services to community services in a manner that can support youth returning or being diverted from residential care will vary across the state. In addition, the group wrestled with the reality that reducing the use of residential services and increasing the use of community and family based services will be a zero sum game (there will be no new funding). Given this context and to not favor or disadvantage any of the provider community, the Department invited not just residential service providers but also therapeutic foster care and family based services providers to this workgroup. DSS will continue to conduct its procurement planning work in accordance with the principle of an open, transparent, and fair process.

As described above, there are other planning efforts underway on the system of care initiative. The focus of these efforts includes case management decision-making roles and responsibilities, the operational and financial relationship of the Area-based Lead Agencies and Regional Resource Centers, implementation and transition planning, establishing outcomes and baseline measures, etc. While it is true that every conversation is related to and informs the others, in order to make progress in the planning and design, each workgroup is asked to focus on particular questions and trust that their colleagues in other workgroups will be guided by the same values and commitments and that all will be successful in meeting their charge.

That said, there were a number of comments and questions about the overall system of care design and the use of a lead agency model that this Workgroup raised that while not directly in their purview are worth noting. The Network Practices subcommittee members were very much concerned with defining case management roles. They strongly endorsed the effort to examine these roles and often wished to be a part of that separate workgroup. Some advocated for assigning a single care manager as the best approach to ensure coherent care / service coordination for a family. This care manager

would authorize and coordinate all services needed by a family, acting as a "hub" at the center of a wheel, connected to all services / supports. Other comments addressed financing issues, reflecting those made by the Procurement Review Workgroup. These include sharing with network providers any financial incentives given to lead agencies, providing some financial predictability to providers, and respecting investments providers have made to deliver services as DSS has previously asked.

Purpose of this Report

The purpose of this report is to share with the community of service providers information that will be helpful to them as they prepare for the changes that the Department will be making in its service system. The Workgroup's three subcommittees each met three or four times to focus on the questions identified in the project statement (attached to this report). The Department also hosted a daylong meeting with leaders from three other states that have implemented similar changes to those contemplated by Massachusetts. They represented EMQ Children & Family Services in Santa Clara County, California; St. Charles Youth and Family Services, a member of Wraparound Milwaukee; and Lester Drenk Behavioral Health Center, part of New Jersey's Partnership for Kids. Their presentations and other materials are available on the DSS website. Although every state begins their system reform from a different starting point, these leaders shared valuable lessons about managing change strategically.

The Workgroup and its subcommittees identified areas in which they needed some clear direction and guidance from DSS about its intent and expectations in order to focus their own discussions and preparatory work. This report attempts to provide as much of that guidance as possible, recognizing that the planning work is still underway and that while broad outlines exist, operational specifics do not. The Department has deliberately structured its planning work to be open and transparent and continues to engage and share with its community of stakeholders its best current thinking. We recognize that the newness of this approach leaves some mistaking inquiry for confusion. However, we also recognize that change is not sustainable unless those who will be effected by it are engaged in shaping it, believe in its value, and support it. This initiative is deliberately structured as a learning and organizational change process. In fact, one definition of systems of care is a *cluster of organizational change strategies* that are based on a set of values and principles that are intended to shape policies, regulations, funding mechanisms, services, and supports. [1]

Three Domains of Change: Clinical, Business / Managerial, and Network Practice

Early in his tenure, Commissioner Spence described a three-tiered approach to fundamentally revising the nature of child welfare practice. [This paper is available on

[1] Stroul, B. *Issue Brief. Systems of Care: A Framework for System Reform in Children's Mental Health*. Washington, DC: Georgetown University Child Developmental Center, National Technical Assistance Center for Children's Mental Health.

the DSS website, under the system of care initiative.] To translate its espoused values into action, the Department must revise its core work processes and policies to align with these values. This requires a simultaneous focus on an integrated revision of practice at three levels of organization: clinical practice, managerial practice, and systemic practice. These levels of practice – the clinical work of frontline staff, the managerial work of supervisors and managers, and the systemic work the Department, family and institutional providers, public agencies, and community organizations – will operate at cross purposes unless they are consistently aligned. The Department intends through training and professional development, the institution of supervisory and management support structures, and through Continuous Quality Improvement processes to keep these values central to our own practice. Together they provide the lens through which we assess the integrity of our approach to child welfare work.

The Community-Connected Residential Services Workgroup similarly recognized that it needed to examine changes required by provider agencies on these three levels of practice and organized its three subcommittees to reflect the Department's approach.

Clinical Practice: Core Practice Values and Guidelines

The system of care procurement is derived from a philosophy of care that is rooted in the Department's core values. They are:

- Child-Driven
- Family-Centered
- Community-Connected
- Strengths-Based
- Culturally Competent and Committed to Diversity
- Committed to Continuous Learning and Innovation

The Department expects that providers who participate in this system will adhere to these values and will incorporate them into practice, policy and management structures and processes. Meaningful adherence to the values will require a full embrace of principles that support them and vigilance to ensure that they are not marginalized or caricatured.

The Workgroup's Clinical Practices subcommittee took on the challenge of responding to providers' requests for clear definition of what DSS means by its core practice values. The values as identified carry multiple possible definitions and interpretations. The Clinical Practices subcommittee developed a set of practice guidelines and indicators of the core values in action in residential programs. They found that the process of developing these indicators to be important in and of itself. Residential providers are encouraged to use these indicators to examine their current practice. One member, who had engaged in a similar process prior to this Workgroup, noted that these values are not always as evident in practice as one hopes or assumes and that every provider can benefit from such a process whether or not they believe they can.

While the indicators are a beginning attempt to clarify what the Department's expectations of its contracted providers, they are not an exhaustive list of the universe of indicators. The more important use of these indicators is as a starting point from which agencies may engage in a process of self-reflection. The values need to be translated by each agency into an approach to practice; in doing so, an agency could develop its own indicators. The Department does not intend through its procurement to prescribe a particular model of treatment. Providers will need to adopt or develop interventions that best meet the needs of the children and families that they serve consistent with these values.

Attached to this report are the following Practice Guidelines and Indicators:
- Strengths-Based Indicators
- Family-Centered Indicators
- Culturally-Competent Indicators
- Community-Connected Indicators for Residential Programs
- Continuous Learning Indicators

The Department's Planning and Program Development managers will develop a parallel set of indicators for family based services programs. We encourage providers to share their additions, modifications, and experience in using these working documents with the Planning and Program Development team.

Business / Managerial Practice: Opportunities and Challenges

The Business Practice Subcommittee approached its work by designing a hypothetical program that met the needs of a family situation (that the group defined based on its experience) according to these practice values. This approach grounded the discussion and allowed workgroup members with a wide variety of perspectives to work together to develop an innovative program that reflects the core practice values. Using this hypothetical program, the subcommittee identified managerial and business opportunities and challenges. It developed the following recommendations, advice, and considerations for both their colleagues in the provider community and for DSS.

- When other states' describe their reductions in residential treatment, they are not suggesting that there are no longer any residential programs at all. What they experienced was a great reduction in the long-term use of residential and an increase in shorter lengths of stay and placement in community based group homes (which we call residential group homes, but other states do not call residential). Some residential providers (e.g. St. Charles in Milwaukee) redesigned their programs and have expanded their services and now work with a greater number of kids than they used to.
- There is general agreement among the Workgroup members (shared by DSS) that there will remain some youth whose behavioral and developmental needs require longer-term care. So, while we expect to see fewer youth in longer-term residential care, those youth are likely to have the most challenging behavioral profiles.

- The unbundling of residential programming is a source of important innovation in the system. The subcommittee contemplated programs that allow youth to move easily from campus to community and back again as necessary. One challenge is identifying the right number of "reservation beds" for the group of youth who will potentially need that type of support. Having available capacity that is not over or under utilized is a challenge on which providers, lead agencies, and DSS will need to work collaboratively. As providers ramp up new programs, they must master the challenge of defining and achieving critical mass as well as how to "bootstrap" or stretch internal resources until critical mass is achieved to support the hiring of sufficient new staff. Some unbundling requires flexibility in the licensing regulations and procedures. For example, after school and recreational programs might benefit from flexibility in staff ratios requirements. Staff ratios at residential / education programs are typically 1:3 or 1:4, while for public school recreation programs 1:15. Could residential programs be licensed specifically for after school programming?
- The subcommittee concurred with the Procurement Review Workgroup's recommendation that the Department use this new system to bring a regional focus to its placements, networks, and relationships with other state purchased systems. Such a focus would support family work and connecting to community by mitigating the negative effect of distance and transportation difficulties. Building regional and local vertically integrated networks starts with building relationships among providers of different types of services. The exception to this approach may be specialty populations, for whom statewide programming is the most feasible approach.
- The Procurement Review Workgroup identified the challenge of balancing the system's need for flexibility with the providers' need for predictable business levels and cash flow. An unpredictable business environment can cause providers to be cautious in developing and maintaining innovative and responsive programs, which ultimately undermines flexibility in the service system. This subcommittee continued to discuss and refine this issue. Providers recognized that they could / would have to broaden the eligibility criteria of a program in order to increase the range of kids they could serve. DSS can't be in the position of paying for services not used while having kids 'stuck' without placements or services. They also recognized that a broader program definition is easier for a larger provider to accomplish than a smaller one.
- The changes in clinical practice require retraining staff. There is a cost to pulling staff off-line for significant retraining, while maintaining safe staffing levels. Many providers have little margin to absorb this cost.
- DSS needs to be a smart purchaser. It needs to know its population well, define and project demand for services, and understand the service market from which it purchaes. This information (qualitative and quantitative) must to be shared with the provider community, as soon as possible in this planning process and frequently throughout the life of the procurement. Some residential providers wanted to know what "magic number" DSS has in mind for a reduction in long-term residential beds. DSS does not have such a number in mind nor is it possible to develop one at this point in time. As the new system evolves and the capability and capacity to assess

and match youth in residential settings with community and family support services increases, the "number" will change.

- Part of DSS' implementation work with its lead agencies and providers will be to identify appropriate increments of change that can be supported and accomplished reasonably. There are implications for campus, staffing, etc. that are not amenable to a "kid by kid" approach. Providers also reminded the Department that it must support a transition process that does not prematurely lose capacity in the system. It is nearly impossible to recover physical / facility capacity once it is gone.
- One of the lessons of similar system reforms in other states is that these changes do not produce a cost savings. In fact, they might even cost more in the first year or so as capacity in the community is built. Additionally, the group noted that we may seek short-term stays in residential settings, but not short-term commitments to kids and their families.
- The subcommittee recognized that the reality of financial pressures on schools dictate that we will need to bring money to the table, not go with our hands out. One provider shared experience with another state, where by bringing human services funds to the schools, the resources that were available in the schools were leveraged to great benefit for the kids.
- As we consider the challenges of "no new money", we must all be mindful that there are a lot of resources already spent delivering services to families and that better coordination of the services supported with these funds is a central goal of the system of care. Integration doesn't mean that we ask partners for their money, nor that they ask us for ours, but that we better integrate our spending and our efforts.
- Providers share the Department's commitment to the value of strengths-based practice. In order to fully realize this practice, they urged the Department to set reasonable expectations for the use of third party billing. Medicaid's focus on "medically necessary" criteria is deficit-oriented and contradicts and undermines any attempt to focus on services in a strengths-based manner. Providers cautioned the Department that its best efforts will not work unless the Medicaid Program consistently reflects the system of care values. There must be coherence across the Municipal Medicaid and Residential Rehab Programs and the DSS service system.
- As with Medicaid, the currently divergent and incoherent business practices of state human services agencies will have a detrimental impact on the functioning of service networks. The best results that can be achieved by the DSS service system will be limited and circumscribed by the business practices of DSS' public partners and fellow purchasers and funders.

Systemic Practice: Building Strong Networks

The Network Practices Subcommittee's focus was the hardest to define. Perhaps because the Department's Commonworks and Family Based Services Programs use lead agencies to develop and manage service networks, discussions about network practice easily turns

to the design and functioning of lead agencies. However, there are important questions about what makes for healthy networks and partnerships that are separate from lead agency design. The Network Practices subcommittee examined the challenge of how to build a single network with its own cohesive identity. Each of DSS' current networks (Commonworks, Family Based Services, Community Connections) has its own identity based on its particular capacity and place in the child welfare system and a pride in its accomplishments. The new system of care will integrate these programs and funds into one system with integrated local networks. In doing so, all partners and colleagues must adapt to a new system that builds on but does not replicate entirely any one of the current networks. Achieving this integration will be evolutionary over a two to three year period of time during which everyone contributes their best and everyone learns from the best of others. To support this, the subcommittee identified tools (e.g., policies, practices, etc.) that DSS needs to build internally, tools that are created or shaped by DSS through the RFR, and tools that are the responsibility of providers as network partners.

- Coherent experience within the service system is critically important for the families, youth, and children with whom DSS is involved. The network practices subcommittee observed that a coherent service network depends on a coherent DSS service management structure. Currently DSS' management of its services is fragmented into group care panels, FBS teams, MDATs, and more. A consistent point of entry would aid the service provider network.
- Families would benefit from a network that has a " bigger front yard" – i.e., a larger space in the network for kids before they enter categorical services or become involved with a categorical agency through a crisis. For example, Supportive Child Care programs are places where early targeted intervention can occur in a natural setting. While child care funds are not part of the DSS budget and system of care procurement, programmatic integration will be critical.
- A network in which all members hold the same values and use the same language is the foundation for effective collaboration and partnership. DSS hopes that readers will use the Practice Guidelines developed by the Clinical Practices Subcommittee to examine their own agency's practice and operations as well as a basis for discussion with potential partners. We especially encourage providers of different service types and those who have not typically been partners to use of these Guidelines to open a broader dialogue.
- Providers noted that the tone set by DSS for working with a family shapes practice from the beginning of a case throughout its duration. Families should expect consistent treatment from DSS and its providers, with all relationships guided by DSS' core practice values. Providers emphasized repeatedly the importance of engaging in a parallel change process internally at DSS.
- Good assessments are critical to effective practice with children and their families. Subcommittee members identified the lack of assessment capacity, specifically the loss of Adolescent Assessment units (AAUs), as undermining effective network practice.

- Effective networks support members in assessing and managing risk. Providers who participated in the previous Commonworks model (Commonworks 1) recall that the size and nature of the network allowed them to consult with colleagues on particular challenges and offer and receive assistance. The network members knew each other's strengths and could draw on those strengths as appropriate (it was more collaborative than competitive). The challenge of the new system is that membership will include a wider range of providers and service types, whereas Commonworks 1 was limited to residential programs. The new networks will also have a strong role for families. This makes the use of a common language all the more important.
- Reasonable and appropriate scale and scope are important factors to consider in designing networks. A network can become too big to manage well. Conversely, it can also be too limited in coverage to be effective if it includes only part of a system. For example, residential placement services are purchased through both Autho and Commonworks, which creates conflict and competition for resources.
- Some providers encouraged the Department to consider allowing bidders to propose a collaborative lead agency model. That is, the lead "agency" would be an entity formed by two or more providers who join their resource collaboratively for this particular purpose.
- A coherent network is one that has a diverse membership that reflects the families that it services. Networks must include smaller agencies and non-traditional members, to whom there should be concerted outreach. Relationships among providers should be formalized. In anticipation of networks with new members and new partnerships, there should be training about how to work effectively in a network.
- Providers are anxious to see how the entire EOHHS children's system of care will be designed and integrated. They hope to see local systems developed, as DSS has proposed for its services. Ultimately, there should be one fully integrated network locally that shares resources across human service purchasing agencies. The network structure should include forums and/or mechanisms to build consensus around resource allocation and access decisions and to resolve disputes in a timely manner.
- The network practices subcommittee identified the importance of performance measures and incentives in shaping the nature and content of a network. Their discussions were similar to findings in a recent report, *Assessing Partnerships*[2], in which the authors report that more and better partnerships exist when:
    - measures of quality of service are plentiful and accurate;
    - estimates of institutional performance are relatively easy;
    - incentives are plentiful and aligned with performance, within and across institutions; and
    - information flows are inexpensive, enhancing learning and feedback.
- All three subcommittees raised the importance of schools as partners. Residential schools receive as much funding from local education authorities as they do from

[2] Klitgaard, R. and Treverton, G. *Assessing Partnerships: New Forms of Collaboration*. RAND Graduate School, published by the IBM Endowment for The Business of Government, March 2003.

DSS. Step down needs to occur and be managed both residentially and educationally. Similar to the observations regarding Medicaid, absent changes in the educational system consistent with the direction of the system of care procurement, DSS' vision will be undermined and constrained.

- Residential programs need to work with schools just as they do with families. Schools have their own dynamics and need to learn skills for supporting a youth's re-entry. Programs need to address the fear of school staff, rebuild bridges, and reintegrate the youth returning to a school from which he/she disrupted.
- Particularly during times of placement transition, the school needs to have accurate information about who is the contact person for the youth, who is supervising attendance, and who is responsible when during 24 x 7 period. Access to a contact person helps create comfort and mitigate risk associated with the youth's re-integration to the school.
- A flexible approach on the part of schools in supporting a youth's transition would help achieve the outcome of increased community tenure. For example, part-time attendance in the public school might be a beneficial for a period of time. Another example is continued attendance at the day school program at a residential school for youth who are ready to live in a community-based group home but not ready for attendance at a public school.
- Schools should be involved in the local service networks as soon as possible. Their involvement should not be limited to working with individual families, but should also include a role in network management / governance. As with all partners, the capacity and obligations of schools must be fully understood and respected in any educational planning that occurs.
- Youth need positive peer relationships at school. Sometimes youth who need the support of DSS become marginalized by public schools and other students. The acceptance and supportive environment that youth find in a residential school are invaluable to their well-being.
- Who youth hang out with and how they spend their time are critically important to a healthy life. The system needs more therapeutic and vocational after school programs for adolescents, particularly those involved with DSS (just as it currently has supportive child care for younger children). One approach to after school is allowing visits back to the residential program.

Next Steps

The following items resulting from the Community-Connected Residential Service Workgroup will be incorporated into the Department's procurement planning work.

- Practice Guidelines and Indicators will be developed for therapeutic foster care and family based services and posted on the DSS website. As with the guidelines for residential programs attached to this report, these documents will be viewed as

"working documents" subject to continuous modification and refinement based on feedback.

- DSS will share the workgroup's advice and concerns about the importance of licensing in supporting re-engineering and unbundling residential services with the EOHHS Purchasing Strategies Initiative licensing workgroup. The Purchasing Strategies Initiative is designed to use DSS' procurement as a "learning lab" in order to support our work with a multi-agency team and to enhance their work by grounding it in current change efforts. The workgroup includes representatives from DSS, OCCS, DOE, and provider agencies.
- The Workgroup has provided important guidance to DSS as it works with its sister human service agencies on integrating financing and purchasing mechanisms. For example, EOHHS has established a workgroup examining the Municipal Medicaid Program, which will include DSS staff.
- DSS will host public information sessions prior to issuing the RFR.

Providers are encouraged to use this information along with the information available on the DSS website regarding the system of care procurement to continue to guide their own planning and readiness work.

- Providers are encouraged to use the Practice Guidelines and Indicators to talk with their own staff about the nature of the changes to the DSS service system.
- Providers might consider developing their own hypothetical program models as a way to identify the opportunities that their agency might pursue and the challenges in doing so. These conversations should involve the families they work with and potential partners in the community.
- There are some limits to the nature and scope of discussions that individual providers can have with DSS Area and Regional Offices in order to not give unfair advantage to one potential bidder over another. Clearly, DSS and its providers must continue to manage the current service system for nearly a year. However, conversations about the future design of the service system belong in forums that are open and inclusive.
- There are no restrictions around providers working with each other and community partners. In fact, DSS encourages providers to not wait for it to issue an RFR, but to begin local dialogues now. Understanding systems of care as a cluster of organizational change strategies requires that this work proceed on multiple levels and in multiple directions. Examining the challenges and opportunities that exists at the three tiers of clinical, managerial, and network practice can and should begin and need not be tied to the formal procurement process.

Reports of Interest

The reports described below are intended as thought provoking and insightful and are offered for readers' interest in support of our collective conversations about the system of care. These reports should not / cannot be read as "tea leaves" about a specific direction the Department might take in the system of care procurement.

Assessing Partnerships: New Forms of Collaboration
By Robert Klitgaard & Gregory F. Treverton, RAND Graduate School
Available at http://www.businessofgovernment.org, under Publications / Reports.
Published by the IMB Endowment for The Business of Government, March 2003

Excerpted from the Executive Summary:
Partnerships among government agencies, business, and non-governmental organizations (NGOs) are a growing reality. They are part of a long-term trend toward "hybrid governance," in which responsibility for "public" policy is mixed among public and private bodies in various combinations. These partnerships come in many shapes and sizes, but the focus in this paper are those that entail active collaboration, not just arms'-length regulation or incidental cooperation. Such partnerships can have a wide range of effects, both positive and negative. How can managers assess what forms of partnerships will lead to what advantages and risks? Can the key management challenges to making partnerships work be identified? What practical insights can be derived from theory? And how can analytical frameworks be turned into useful tools for a given institution to think through whether and how to partner?

Partnerships can be assessed from three perspectives:
- The first is would-be partners asking, "What's in it for me and my institution?"
- From a second perspective, the question for managers, evaluators, or policy makers broadens to, "What are the effects on society of this partnership, compared to the alternatives?"
- The third perspective opens the aperture still wider to ask, "How can government and the private sector create a policy environment in which the right partnerships develop over time?"

Also available at http://www.businessofgovernment.org, under Publications / Reports, is **Communities of Practice: A New Tool for Government Managers**, by Xavier de Souza Briggs and William M. Synder

Strategic Restructuring: Findings from a Study of Integrations and Alliances Among Nonprofit Social Service and Cultural Organizations in the United States
By Amelia Kohm, David La Piana, and Heather Gowdy
Chapin Hall Center for Children, June 2000
Available at http://chapinhall.org

Excerpted from the Summary:
The nonprofit landscape is changing. Due to a variety of forces, many nonprofit organizations are looking at new ways to manage and finance their programs, including an approach we call strategic restructuring. Strategic restructuring occurs when two or more independent organizations establish an ongoing relationship to increase the administrative efficiency and/or further the programmatic mission of one or more of the participating organizations through shared, transferred, or combined services, resources, or programs. Strategic restructuring ranges from jointly managed programs and consolidated administrative functions to full-scale mergers.

Drawing on survey results from 192 non profit social services and cultural organizations, the authors devised a typology that includes two primary types of restructuring.

- Alliance: An alliance is a strategic restructuring that includes a commitment to continue for the foreseeable future, shared or transferred decision-making power, and some type of formal agreement. However, it does not involve any change to the corporate structure of the participating organizations. The alliance category includes administrative consolidation and joint programming partnerships.
  The survey found more alliance than integrations.
- Integration: An integration is a strategic restructuring that includes changes to corporate control and/or structure, including the creation and/or dissolution of one or more organizations. The integration category includes management service organizations, joint ventures, parent-subsidiary structures, and mergers.

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System of Care Procurement
Community-Connected Residential Services Workgroup
Statement of Purpose (Updated October 2003)

It is increasingly clear that a central factor in building a comprehensive community-based system of care is unlocking the tremendous capacity of residential service programs. While there are children/youth for whom long-term residential care is appropriate, there are many children/youth who could be better cared for through a more flexible, individualized combination of community-based and out-of-home placement services. Moving to a system of care that allows a flexible use of a wide array of resources requires residential services to evolve in two critical ways. First, the knowledge currently held in residential programs must be made available in community services / settings. Residential treatment providers have a great deal of expertise in behavior management that is currently delivered only in institutional settings. This expertise should be accessible to children and their families in community and in-home settings. Second, residential services should be designed to provide back-up to community services in the form of crisis response, stabilization, assessment, and respite.

Mandate for This Workgroup
Recognizing that there are other forums and workgroups charged with designing and building local systems of care, this workgroup is being convened to focus on residential services. Specifically, this group will be charged with identifying the organizational changes required within residential programs to support local systems of care; strategies for achieving these changes; impediments to making changes; and finding and sharing resources to support change. Examples of changes anticipated include, but are not limited to, retraining staff; aligning operations and practice with a family-centered, community-based philosophy of care; and shifting capacity from facilities/campuses to communities. At a conference sponsored by the Center for Health Care Strategies, providers of residential services reported that the substantive organizational changes that they undertook in their programs required 18 months to implement.

The workgroup will establish three subcommittees, as described below. The purpose of this structure and the proposed topics is to allow this group to be a Peer Advisory Group to the provider community via DSS. There are two key deliverables for the group:

- A Readiness Assessment Guide for the provider community
- A Communication strategy for DSS to present to and engage the provider community in systems change work

Clinical Practices subcommittee
The Department and the Procurement Review Workgroup have articulated principles for designing a system of care that are to be reflected in all purchased programs. The Department has also put forth a vision for increasing community tenure and ensuring that no child enters adulthood alone but has sustained healthy relationships with a caring adult. Residential Programs hold a great deal of expertise in treatment for children who require high levels of containment, and frequent, intensive interventions to help them

achieve lasting academic and social success. A critical contribution of residential programs will be to provide short term, intensive placement stabilization services for these youth and to then continue that care in the home or community.

- How is care provided in the milieu setting shaped or changed by the principles for the system of care (family-centered, community-based, culturally competent, strengths-based, etc.) as well as by the focus on increasing community tenure?
- How can residential programs support clinical and behavioral interventions in the home or other family settings that have been traditionally delivered within the contained campus setting?
- How will clinical care management need to be structured in order to ensure continuity of care between placement and home?
- What are the implications for supervision and training of staff?

Management & Business Practices subcommittee
Residential Programs have resources and service elements that could be "unbundled" and purchased separately to support the unique needs of communities within their geographical area. Because each community is unique in its needs and capacities, they may want to purchase different elements.

- What would a provider have to do to design and deliver an 'unbundled' service?
- How would they price it so that it could be staffed appropriately and available when needed (while minimizing the cost of unused capacity)?
- How are the principles (e.g. strengths-based, family-centered, community-based, culturally competent, etc.) reflected in a provider's administration, program development, and continuous quality improvement activities? What are the indicators of the principles in action in a residential program?

Provider Network subcommittee
DSS is designing its service system using a lead agency model (as described in the Procurement Review report). The lead agency will have a care management / care coordination role (tbd by another group) and will manage a network of service providers. At a client level, the Department is seeking improved outcomes in safety, permanency, and well-being. At a system level, the Department is seeking improved outcomes in the domains of access, quality, and cost.

- How can we organize the network system so that it has coherence (and is not a source of confusion) for DSS, the lead agencies, and network providers?
- What are the network structures and processes that provide a meaningful and effective role and voice to network members?
- What types of relationships might exist between / among providers in a network? E.g., affiliations, partnerships, new business ventures, etc.